MEDICAL SCREENING FORM

For corrections officer to determine upon initial appearance:

Y / N 1) Does youth have any visible signs of trauma, illness, obvious pain or bleeding?
Y / N 2) Does youth have signs of breathing difficulty or shortness of breath?
Y / N 3) Is there obvious fever, swollen lymph nodes, jaundice or other evidence of infection?
Y / N 4) Are there any signs of poor skin condition, vermin rashes or needle marks?
Y / N 5) Does youth appear to be under the influence of drugs or alcohol?
Y / N 6) Does youth have any physical deformities?

Questions to be asked of youth:

Y / N 1) Have you recently been hospitalized or treated by a doctor?
Y / N 2) Do you currently take medication as prescribed by a doctor?
Y / N 3) Are you allergic to any medication?
Y / N 4) Do you have a special diet as prescribed by a doctor?
Y / N 5) Do you have any problems or pain with your teeth?
Y / N 6) (Female Only) Are you currently pregnant or on birth control?
Y / N 7) Do you have any other problems we should know about?

Do you, or have you ever had any of the following: (CIRCLE ANY THAT APPLY)

AIDS	HEPATITIS	TUBERCULOSIS
ALLERGIES	FAINTING SPELLS	ULCERS
ARTRHITIS	HEART CONDITION	SEIZURES
ASTHMA	HIGH BLOOD PRESSURE	SEXUALLY TRANSMITTED DISEASE
DIABETES	PSYCHIATRIC DISORDER	OTHER (SPECIFY): _____
EPILEPSY	PREVIOUS BACK INJURY	_____

*MEDICAL ALERT INFORMATION:

Explanations/Comments (Refer to item number.)

MEDICAL INSURANCE: _____ PERSONAL DOCTOR: _____
EMERGENCY CONTACT: _____ RELATIONSHIP: _____
ADDRESS/PHONE: _____

I DO HEREBY AUTHORIZE THE ATTENDING PHYSICIAL AND MEDICAL STAFF TO PROVIDE SUCH SERVICES AND TREATMENT AS DEEMED REASONABLE AND NECESSARY FOR MY HEALTH AND WELL-BEING WHILE I AM IN THE CURRENT CUSTODY OF THE GREAT FALLS YOUTH TRANSITION CENTER. IF NECESSARY, I FURTHER AUTHORIZE ACCESS TO MY MEDICAL RECORDS, PAST AND PRESENT, WHETHER TREATMENT WAS AT PUBLIC OR PRIVATE EXPENSE

_____
Youth's Signature